(IZ Heading)

Summer 2008
Vol 14 –No. 2

Measles Advisory:

On May 1, 2008 the CDC released a MMWR and held a press conference about the Measles cases (Jan 1-April 25, 2008) in 9 states and reported outbreaks going on in 4 states: Wisconsin, Arizona, Michigan, and New York. Washington state was added to the outbreak list on April 26, 2008. The CDC had received a total of 64 reports of confirmed cases of measles in the U.S. This is the highest number reported for the same time period since 2001. The CDC stated, of the 64 cases ranging from 5 months to 71 years of age, 59 occurred among U.S. residents and 54 were associated with importation of measles from other countries. Sixty-three patients were unvaccinated or had unknown vaccine status, but only one patient had received two doses of the MMR vaccine. Only 14 patients were hospitalized and no deaths have been reported.

Since April 30, 2008 Washington state has confirmed 15 cases of measles that originated in a large church gathering of youth and adults from many states and countries. It is known that some Montana residents did attend this church event. This church gathering was held in Kirkland, Washington March 25-29, 2008. The index case was a student from Japan who is reported to have developed symptoms of measles shortly after arriving in the United States. All participants have been informed of their potential exposure to measles and have been educated about appropriate measures by the Public Health Seattle King County.

Measles can be a severe and life threatening illness. Healthcare providers and public health officials should be aware that measles can be acquired through international travel to many countries. During 2008, measles importations have occurred from Switzerland, Israel, Belgium, India, Italy, and likely China, but they can occur from almost any country. On going measles virus transmission was declared eliminated in the U.S. in 2000, but the risk of cases and outbreaks from imported disease remains. However, the vaccine against measles is highly effective in preventing infections. The MMR vaccine is strongly endorsed by medical and public health experts as safe and effective. High immunization levels in the community are effective at preventing or drastically decreasing the size of outbreaks. All children should receive two doses of MMR vaccine. The first dose is recommended at age 12-15 months and the second dose at 4-6 years of age. All adults born in or after 1957 should receive at least one dose of vaccine unless they have documented evidence of measles immunity. Healthcare workers and providers should receive two MMR's if they are not able to prove immunity.

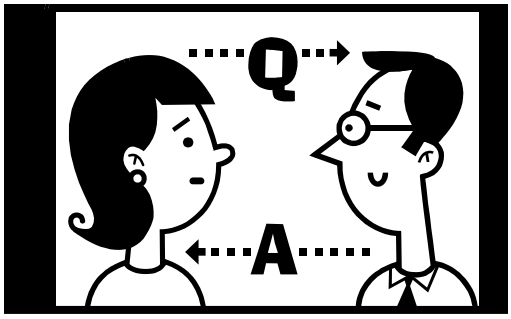
Remember, individuals with measles are typically contagious from 4 days before the rash through 4 days after illness onset.

To access the MMWR article released on May 1, 2008 please use the following website address: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm57e501a1.htm

Clinicians should maintain a high index of suspicion for measles in patients who have the following symptoms:

- ☐ Koplik spots that may appear on buccal mucosa 1-2 days prior to rash
- ☐ Prodrome of fever, cough, coryza and conjunctivitis for 2-4 days
- ☐ Generalized maculopapular rash that usually begins on the face
- ☐ Complications of measles include otitis media, bronchopneumonia, laryngotracheobronchitis, diarrhea, and encephalitis

Suspected cases should wear a mask covering the nose and mouth and be kept away from patient waiting rooms. You must report suspected cases to your local and state public health department immediately.



Why Do So Many Doctors and Scientists Believe the MMR Vaccine Does NOT Cause Autism?

In 2000, the Institute of Medicine (IOM) at the National Academy of Sciences, at the request of the Centers for Disease Control and Prevention (CDC) and the NIH, conducted a review of all the evidence related to the MMR vaccine and autism. This independent panel examined completed studies, on-going studies, published medical and scientific papers, and expert testimony to assess whether or not there was a link between autism and the MMR vaccine. The IOM concluded that the evidence reviewed did not support an association between autism and the MMR vaccine. This and other conclusions from the IOM review were released in April 2001 (Immunization Safety Review Committee 2001).

Also in 2000, The American Academy of Pediatrics (AAP), a professional organization for pediatricians with over 55,000 members, held a conference on the MMR vaccine and autism. Parents, scientists, and practitioners presented information on this topic to a multidisciplinary panel of experts. Based on its review, the AAP also found that the available evidence did not support the theory that the MMR vaccine caused autism or related disorders. The AAP policy statement appeared in the May issue of Pediatrics (Halsey et al 2001).

In 1999, Taylor and colleagues published a study (Taylor et al 1999) that argued against the suggested link between autism and the MMR vaccine suggested by Andrew Wakefield's study. Taylor's study looked at all the known cases of Autism Spectrum Disorder (ASD) in children living in certain districts of London who were born in 1979, or later. Researchers then matched the ASD patients with an independent registry of vaccinations. The results of this study showed that:
The number of ASD cases had increased steadily since 1979, but there was no accentuation of the increase in the number of cases after doctors started using the MMR vaccine in 1988. Children showed symptoms of ASD and were diagnosed with ASD at the same ages, regardless of whether they were vaccinated before or after 18 months of age. This finding is important because if the MMR vaccine caused ASD, the children who were vaccinated earlier would show symptoms earlier. By age two, vaccination coverage (the number of children who received vaccines) among children with ASD was nearly the same as vaccination coverage for children the same age who did not have ASD throughout the region. If the MMR vaccine and ASD autism were linked, then a greater number of children who had been vaccinated throughout the region would have ASD. The first signs of autistic behavior or first diagnosis of ASD was not more likely to occur in time periods following the MMR vaccine than in other time periods.

Also in 1999, the United Kingdom's Committee on Safety of Medicine examined hundreds of reports collected by lawyers of patients with autism and similar disorders that families said they developed after receiving the MMR or MR vaccine. After a systematic, standardized review of the case information, the Committee found that the information did not support any link between vaccines and autism. Based on the evidence, the Committee concluded that there was no cause for concern about the safety of MMR or MR vaccines (Medicines Commission Agency 1999).

A study, done in Sweden in 1998, also showed no evidence of association between the MMR vaccine and autism. The study compared the number of autism cases in children from two Swedish towns before 1982, when local doctors first started using the MMR vaccine, and after 1982.

The results showed no difference in the rate of autism between the two groups of children in either town (Gillberg & Heijbel 1998).
Another study, done in England in 1997, looked at any possible link between the measles-specific vaccine (one part of the MMR vaccine) and different problems that result from damage to the nervous system, such as learning disabilities and behavior problems. These researchers found no proof that the measles vaccine was in any way linked to long-term damage to the nervous system (Miller et al 1997).

Why do People Think the MMR Vaccine Can Cause Autism?

Some parents and families of children with autism believe that the Measles/Mumps/ Rubella (MMR) vaccine caused their children's autism. These parents report that their children were "normal" until they received the MMR vaccine. Then, after getting the vaccine, their children started showing symptoms of autism. Because the symptoms of autism can begin to occur around the same time as the child's MMR vaccination, parents and families see the vaccine as the cause of the autism. However, temporal relationships do not necessarily imply causation. Events linked in time only may be coincidental. Unfortunately, for some parents seeking answers as to the cause of their child's autism, the coincidence in timing of MMR vaccination with the onset of autism disorders sets the stage for suspicion that MMR may be the causative agent. Such belief was reinforced by a small study of bowel disease and autism, published by Wakefield and his colleagues in 1998 (Wakefield et al 1998). The authors relied on the reports of parents and families of the 12 children with autism involved in the study to make their suggestion of a link between the MMR vaccine and autism. Wakefield et al. did not provide proof that there was any link. A number of other studies purporting a link between the MMR vaccine and autism (Singh et al. 1998; Horvath et al. 1999; O'Leary et al. 2000; Wakefield et al 2000; Kawashima et al 2000) have failed to provide scientific as well. To date there is no definite, scientific proof that any vaccine or combination of vaccines can cause autism.

Wakefield's study has been discredited. The other named authors have withdrawn their support following allegations indicating Wakefield was paid by the parents of children involved in the study.

MMR Reminders

- ✓ All children should receive 2 doses of MMR. First dose should be received at 12-15 months and second dose should be received at 4-6 yrs.
- ✓ All adults born in or after 1957 should receive at least one dose of MMR, unless they have documented evidence of immunity.
- ✓ All health care workers or persons who work within a medical facility should have had 2 doses of MMR or have evidence of immunity to measles, mumps, and rubella. Healthcare workers who have just received their first dose must wait at least 4 weeks between dose one and dose two.

Adolescent Immunization Information:

Presently three vaccines, Tetanus, Diphtheria, and Pertussis (Tdap), Human Papillomavirus (HPV), and Meningococcal are recommended by ACIP to be given universally to 11-12 year olds. Persons younger or older than adolescents may receive these vaccines in certain situations. One dose of Tdap is routinely suggested for all persons up to 65 years of age. HPV can be given to females between 9-26 years of age. Meningococcal vaccine is given to college freshman who live in dormitories or any person between 2 and 65 years of age who is at high risk.

Beginning fall of 2008, all adolescents should annually receive influenza vaccine. In addition, adolescence is a great time to "catch-up" on immunizations. If the 11-19 year old has not had Pneumococcal, Hepatitis A, Hepatitis B, Polio, Measles, Mumps, and Rubella (MMR) or Varicella vaccines, adolescence is the time.

Adult Recommendations May Apply to Adolescents

Adolescents may be employed in occupations requiring specific immunizations. Young adults are often travelers and need to consider vaccines based on where in the world they are traveling.

Resources Available for Assuring Adolescent Immunization

Centers for Disease Control and Prevention (CDC) and Montana Immunization Program have some resources to assist you in assuring the adolescents in your area are appropriately immunized. Vaccine resources include the Vaccines For Children (VFC) program; VFC may serve eligible children through 18 years of age. In addition, funding appropriated by the 2007 Montana Legislature will purchase approximately 3900 doses of HPV to be distributed to public clinics this summer.

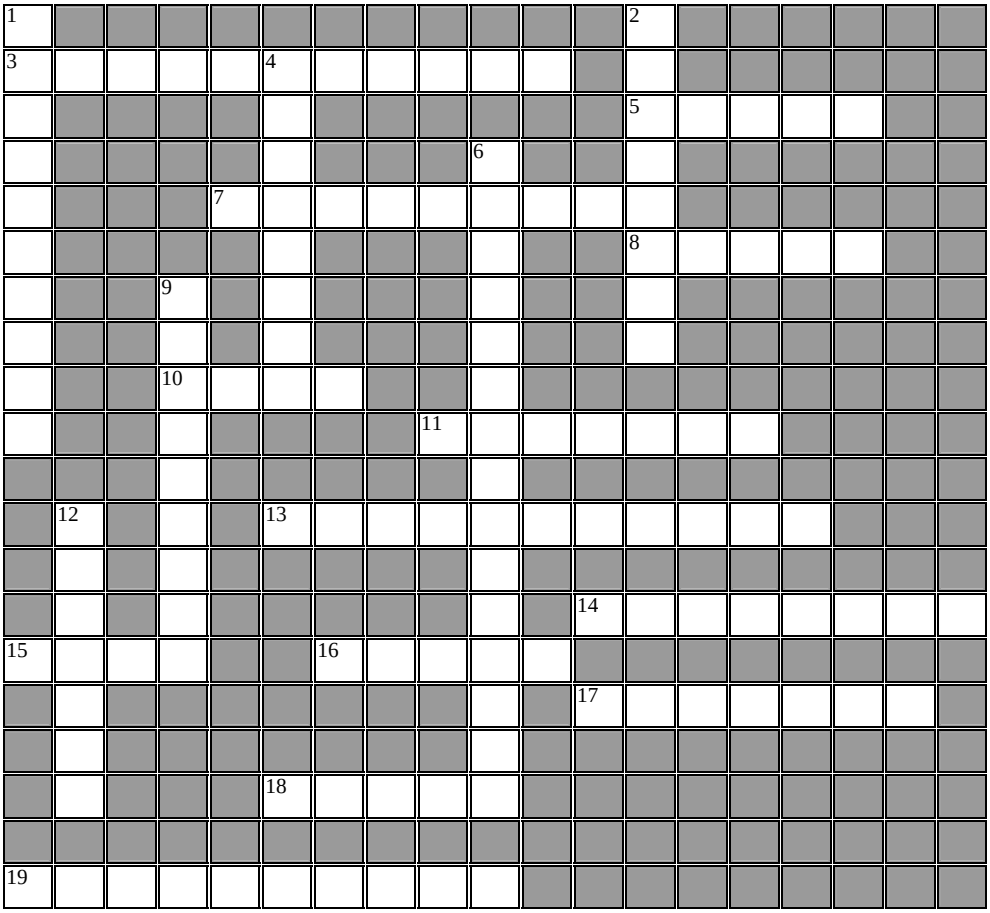
Montana Immunization Program has produced a brochure targeted at 11-19 year olds. The brochure is based upon materials available from the Immunization Action Coalition (IAC) and CDC. Copies can be obtained by sending an email request to jgedrose@mt.gov . Please include the physical address to which they may be delivered by a carrier such as UPS; (box numbers can not receive such deliveries).

Specific materials for adolescent immunizations can be found on the CDC website at www2.cdc.gov/nip/adultImmSched . The IAC also has materials designed to catch the attention of adolescents. You can visit their website at www.immunize.org . On the listed websites, are some computer "tests" adolescents can take to determine whether or not they are adequately immunized.

Epidemiology & Prevention of Vaccine-Preventable Diseases Course 2008

This year the CDC webcast series is not being delivered via satellite or as a live webcast due to escalating costs and limited availability of the CDC broadcast facility. On May 1, 2008 the CDC released this four part series on the web and the Immunization Program has DVD's available for you to check out. This four part series is a comprehensive overview of the principles of vaccination, general recommendations, immunization strategies for providers, specific information about vaccine-preventable diseases and the vaccines that prevent them. The twelve hour course is presented in four 3-hour sessions on DVD or Web-On-Demand. Continuing Education credits are available for each 3-hour session. If you would like to view this series on the web go to: http://www.cdc.gov/vaccines/ed/epivac/default.htm . For those of you who would like to check out a copy of the DVD please contact Lori Rowe at 444-2969 or email to: lrowe@mt.gov . If you would like to order your own DVD copy of this series, you can order this item on the Online Publications Order Form at: www2a.cdc.gov/nchstp_od/PIWeb/niporderform.asp request item #998177.

This Puzzle is about Varicella



CROSS

3. virus group
5. suvival time in enviroment
7. complication
8. isolated from tissue culture
10. first on the head
11. A prodrom of infection
13. transmission
14. recovery results in
15. zoster vaccine is
16. 1 per 60,000
17. less contagious than
18. reservoir

DOWN

1. primary infection
2. vaccine for zoster
4. recurrent infection
6. 2-3 per 1,000 cases
9. occurance
12. one specimen source

SAVE THE DATE!!!! SAVE THE DATE!!!! SAVE THE DATE!!!!

Thursday August 14 and Friday August 15
HIV/STD/HEPATITIS: ASKING the HARD QUESTIONS

Montana's HIV/STD/HEPATITIS Conference to be held at
Carroll College in Helena

FAQs: Perinatal Hepatitis B Program

- **How is Montana doing with birth doses of Hepatitis B Vaccine?**
  According to the 2006 National Immunization Survey which evaluates the percentage of birth doses received within the first 3 days of life . In Montana: Day 1 – 55%; Day 2 - 61%; Day 3 – 62%; The doses were given almost 2 years ago. We are optimistic that our current birth dose numbers are higher. Continue your good work and keep in touch with your birthing hospitals to encourage greater protection of Montana babies with the birth dose safety net.

- **Does a known Hep B positive woman have to be tested with each pregnancy? What if another mom is negative from previous pregnancy and known to be low risk?**
  ***Yes in both instances*.** Status can change. Perhaps the infection has resolved and she's now immune; maybe she has a new partner; has been recently exposed, and is a new positive. Remember a person considered low risk can be exposed by more than just sexual or IDU activity.

- **What do I do if the mother moves away prior to or after delivery?**
  It is important, on first contact, with the positive mom, to find out her living situation and any plans to move during the prenatal/ postpartum time. Attempt to obtain a name, address and number of an "anchor" person who can be contacted when client is unreachable. This might be a relative or close friend. Gathering this "anchor" information should also be done again at hospital discharge so that the baby can be located for public health follow-up. Encourage the mom to call you for any change in residence. Let the state coordinator know ASAP as she may be able to assist.

- **How long do we follow-up with the baby/family?**
  The local case manager follows the baby to assure the full series of hepatitis vaccine is given on schedule and the labs, ***both the HBsAg and Anti HBs** are done at the correct time. If results are: HBsAg non reactive (neg) & the Anti HBs reactive, the child is immune. Send the results to the state coordinator and the case can be closed after a review of precautions with family. If the HBsAg is reactive, the baby may be a new case and needs immediate medical attention. If both are negative, consult with the coordinator regarding re-vaccination.

- **What if the birth weight is <2,000 g (4lb 6.5oz)?**
  See accompanying chart.

** **Indicates MT State Adm. Rule: 37.114.540**

If you have any question regarding Perinatal Hep B you can reach Nancy Demoro, RN at 444-1805 or email ndemeoro@mt.gov

Hepatitis B Immunization Management of Preterm Infants Weighing <2,000 g, by Maternal Hepatitis B Surface Antigen (HBsAg) Status

Maternal HBsAg status	Recommendation
Positive	• Administer HBIG* + single-antigen hepatitis B vaccine within 12 hrs of birth. • Administer HBIG^ + single-antigen hepatitis B vaccine within 12 hrs of birth. • Do not count the birth dose as part of the vaccine series. • Administer 3 additional hepatitis B vaccine doses with - single-antigen vaccine at ages 1, 2–3, and 6 mos, *or* - hepatitis B-containing combination vaccine at ages 2, 4, and 6 mos (Pediarix) or 2, 4, and 12–15 mos (Comvax). † • Test for HBsAg and antibody to HBsAg 1–2 mos after completion of >3 doses of a licensed hepatitis B vaccine series (i.e., at age 9–18 mos, generally at the next well-child visit). Testing should not be performed before age 9 mos nor within 4 wks of the most recent vaccine dose.
Unknown	• Administer HBIG + single-antigen hepatitis B vaccine within 12 hrs of birth. • Test mother for HBsAg. • Do not count the birth dose as part of the vaccine series. • Administer 3 additional hepatitis B vaccine doses with - single-antigen vaccine at ages 1, 2–3, and 6 mos, *or* - hepatitis B-containing combination vaccine at ages 2, 4, and 6 mos (Pediarix) or 2, 4, and 12–15 mos (Comvax). *
Negative	• Delay first dose of hepatitis B vaccine until age 1 mo or hospital discharge. • Complete the hepatitis B vaccine series with - single-antigen vaccine at ages 2 mos and 6–18 mos, *or* - hepatitis B-containing combination vaccine at ages 2, 4, and 6 mos (Pediarix) or 2, 4, and 12–15 mos (Comvax). *

* The final dose in the vaccine series should not be administered before age 24 weeks (164 days).
^ Hepatitis B immune globulin

NOTE: This table is a replacement for Table 4 in A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP). Part I: Immunization of Infants, Children, and Adolescents (MMWR 2005, Vol. 54, No. RR-16, page 9). A list of the major errata appeared in MMWR on December 7, 2007.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention
Division of Viral Hepatitis
www.cdc.gov/hepatitis

Educational Events/Resources:

In March the Immunization program received a new web address. That web address is www.immunization.mt.gov. Please visit our website for updates, forms, VFC information, and educational resources. We do have a section devoted to Adolescent Immunizations. There are several power point presentations, specifically targeted to nurses who are interacting with parents of adolescents on our website. The material in these presentations could be extracted and re-worked for presentations to local parent groups.

There is also a new self study course available on the CDC's website called "*Increasing Adult Vaccination Rates: What Works.*" This interactive web-based training course focuses on strategies that have proved effective in increasing adult vaccination rates. *What Works* was developed through a Cooperative Agreement between NCIRD and the Association for Prevention Teaching and Research. This course can be done at your own pace, is free of charge, has continuing education credits through the CDC, can be used as a reference, and can be accessed at anytime. This training program offers you the opportunity to review information about effective strategies (such as standing orders, chart reminders, mailed/telephone reminders), test knowledge of vaccines recommended for adults, explore facts about vaccine-preventable diseases affecting adults, and access reference/resource materials. The course is intended for primary care practitioners such as physicians, nurses, nurse practitioners, physician assistants, and is also appropriate for other health care professionals who provide immunization services and education to adults. You can access this web study course at www.2a.cdc.gov/vaccines/ed/whatworks/index.html If you have any questions please contact Lori Rowe, Distance Learning Coordinator, at 444-2969.

In early June, the CDC released new Shingles print Ads. They have 2 fact sheets, a "Shingles Personal Story" Ad, and a Shingles Poster. Some of the print files are large and can take several minutes to download. You can find these ads on the CDC website at www.cdc.gov/vaccines/vpd-vac/shingles/print-ads.htm . Go and check it out!



"Those of us at a certain age remember the beautiful and versatile dancer Cyd Charisse who died in June at 86 years of age. She was trained in a classical ballet and danced in MGM musicals as well. What we may not know was that she was a "sickly" child due to polio. She was put into ballet at age 6 to build up her strength."

Adult Immunization

Adults born in 1957 or later who are not immune to measles, mumps, or rubella should be immunized.

Women 26 years of age or younger should be immunized against human papillomavirus (HPV), the vaccine contains 2 strains of the virus that cause about 70 percent of all cervical cancer cases in the U.S.

All adults 65 years of age or older, as well as persons 2 to 64 years of age who have diabetes or chronic heart, lung, liver or kidney disorders need protection against pneumococcal disease, and should consult their healthcare providers regarding this vaccine.

Influenza vaccination is recommended for all adults 50 years of age or older, women who will be pregnant during influenza season, and residents of long-term care facilities, as well as for all children 6 months through 18 years of age. Other individuals who should seek annual influenza immunization include healthcare workers and those who live with high-risk persons, including those who live with or who provide care for infants younger than 6 months of age.

Hepatitis B vaccine is recommended for adults in certain high-risk groups, such as healthcare workers and public safety workers exposed to blood on the job, household and sex contacts of persons with chronic hepatitis B virus (HBV) infection, sexually active people who are not in long-term, mutually monogamous relationships, people seeking evaluation or treatment for sexually-transmitted disease (STD), men who have sex with men, injection drug users, travelers to countries where HBV infection is common, people with end-stage renal disease and HIV-infected persons. Hepatitis B vaccine is also recommended for anyone seeking protection from HBV infection.

To increase vaccination rates among people at highest risk for HBV infection, hepatitis B vaccine is recommended for all adults in the following settings: STD treatment facilities, HIV testing and treatment facilities, facilities providing drug-abuse treatment and prevention services, healthcare settings targeting services to injection-drug users or men who have sex with men, correctional facilities, end-stage renal disease programs and facilities for chronic hemodialysis patients, and institutions and nonresidential daycare facilities for persons with developmental disabilities.

All adults require tetanus and diphtheria (Td) immunizations at least every 10 years throughout their lives. Adults who deferred Td boosters during 2001 and early 2002 because of vaccine shortages should get back on track – the supply problems have been resolved. Additionally, adults younger than 65 years of age should substitute a tetanus, diphtheria, acellular pertussis (Tdap) vaccination for one Td booster. Any adult under 65 years of age who comes in contact with infants should receive a Tdap vaccine.

Ask the Experts: Answer to Your Zoster Questions.

Should people who haven't had chickenpox be vaccinated with zoster vaccine?
Serologic surveys indicate that almost everyone born in the United States before 1980 has had chickenpox. As a result, there is no need to ask patients age 60 years and older for their varicella disease history or to conduct lab tests for serologic evidence of prior varicella disease. A person age 60 years or older who has no medical contraindications, is eligible for zoster vaccine regardless of their memory of having had chickenpox.

Can someone who has experienced an episode of shingles be vaccinated with the zoster vaccine?
Yes. Shingles vaccine is routinely recommended for all persons age 60 years and older who do not have contraindications.

How soon after experiencing a case of shingles can a person age 60 years or older receive zoster vaccine?
The general guideline for any vaccine is to wait until the acute stage of the illness is over and symptoms abate.

Can you give zoster vaccine to persons younger than age 60?
FDA has licensed the vaccine only for persons age 60 years and older. CDC does not recommend off-label use of zoster vaccine for persons younger than 60 years.

When reconstituted, the volume of zoster vaccine is 0.65 mL. Should 0.65 mL or 0.5 mL be administered to the patient?
The recommended dose for zoster vaccine is the fully reconstituted amount, 0.65 mL.

Is there an upper age limit for receipt of the zoster vaccine? Some clinicians are reluctant to give the vaccine to persons age 80-plus years.
There is no upper age limit for zoster vaccine. The incidence of herpes zoster increases with age. About 50% of persons living until age 85 years will develop zoster.

People are picking up zoster vaccine at local pharmacies and transporting it to the physician's office to be given. Should this vaccine be given?
Zoster vaccine must be stored in the freezer at 50 F (-15 C) or colder at all times until ready for use. If the vaccine has been out of the freezer for more than 30 minutes, it should not be used unless a state health department or Merck has authorized its use.




How do I complete the hepatitis A vaccine series after 1 or 2 doses of Twinrix® have already been given?

Twinrix is licensed as a 3-dose series for persons age 18 years and older. If Twinrix is not available or if you choose not to use Twinrix to complete the Twinrix series, you should do the following: If 1 dose of Twinrix was given, complete the series with 2 adult doses of hepatitis B vaccine and 2 adult doses of hepatitis A vaccine. If 2 doses of Twinrix were given, complete the schedule with 1 adult dose of hepatitis A vaccine and 1 adult dose of hepatitis B vaccine.

Rabies Control and Prevention

Contributed by Kammy Johnson, DVM, PhD and Bonnie Barnard, MPH, CIC

Rabies is a viral disease that affects all warm-blooded animals. It is usually transmitted through a bite from an infected animal. Early symptoms of rabies in humans are nonspecific, consisting of fever, headache, and general malaise. As the disease progresses, neurological symptoms appear and may include insomnia, anxiety, paralysis, and hydrophobia (fear of water). Death usually occurs within days of the onset of symptoms. Symptoms of rabies in humans occur an average of 30 to 50 days after exposure to a rabid animal; however, symptoms can occur as early as 14 days or as late as a year after exposure. Fortunately, rabies in humans is extremely uncommon; only one or two cases have been reported annually in the U.S. in recent years. The last cases in Montana were deaths in 1996 and 1997, both associated with unrecognized and unreported exposures to bats.

During 2007, 544 animals were tested for rabies in Montana; 22 (4%) were rabid. While most rabid animals were wildlife (bats and skunks), domestic pets and livestock were also affected. Almost two-thirds of these rabid animals exposed humans to rabies.

Health care providers should advise persons who have been bitten by an animal or handled a suspect rabid animal to wash wounds with soap and water or provide wound care to the person bitten. Health care providers and bite victims should then consult with local public health authorities to 1) report a potential rabies exposure, 2) obtain assistance with decisions on how to manage the animal and 3) assess the need for rabies post-exposure prophylaxis (PEP) 4) evaluate the need for a Tdap or Td. A rabies consultation and risk assessment with public health authorities should take place *prior* to administration of PEP.

One of the primary ways to prevent rabies is to avoid contact with wild animals, particularly those showing odd or aggressive behavior. Wild animals often become aggressive, lose their fear of people and other animals, or become active during unusual times of the day (e.g., bats active during the daytime). Exclusion of wild animals, particularly bats, from homes or occupied spaces will minimize human contact with key wildlife rabies reservoirs. Keeping rabies vaccination up-to-date for pets provides protection for the animal and a buffer between rabies in wildlife and in humans.

Due to renovations at production facilities, IMOVAX Rabies Vaccine (Sanofi-Pasteur) will temporarily be available only for post-exposure prophylaxis after May 19, 2008. In addition, Novartis, the other supplier of rabies vaccine in the US, currently has limited amounts of rabies vaccine, RabAvert, which is available for PEP use only. If you receive an inquiry about pre-exposure vaccination please refer the inquirer to the PHSD Immunization Section. It is expected that additional RabAvert will be available to the market by approximately July 2008. For more information on the vaccine shortage:http://www.cdc.gov/rabies/news/2008-05-20_PreEVax.html.

The June supplemental issue of *Montana Public Health* contains more details about rabies incidence and prevention in Montana. (http://www.dphhs.mt.gov/PHSD/prevention_opps/MT-PH-prevent-opps-newsletters.shtml)

Recommendations for health care providers caring for persons bitten by animals

- Report all potential rabies exposure to local public health officials. http://www.dphhs.mt.gov/PHSD/epidemiology/documents/countycontacts.pdf
- Consult with local public health professionals to assess if rabies post-exposure prophylaxis (PEP) is indicated.
- Irrigate and cleanse wound; provide wound care to prevent infection. Assess need for tetanus prophylaxis.
- When indicated, ensure PEP is administered properly. Administration of rabies PEP is urgent but not a medical emergency.

Recommendations for public health care professionals responding to persons bitten by animals

- Ensure adequate wound care for bite victim.
- Investigate animal bite or potential exposure incident.
- Assess risk of rabies exposure and need for PEP using incident information.
- Provide for management of biting animal, including rabies testing, if necessary.

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